Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 R B. WING _ FCL001114 05/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1313 ELRADO STREET MERCIFUL HANDS BURLINGTON, NC 27217** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {C 000} Initial Comments {C 000} Report by Paul Dixon A Biennial Follow-Up Survey was conducted on May 5, 2015 from 9:15 AM to 9:50 AM. Not all previously cited deficiencies have been corrected; therefore further action is required. {C 174} Building Equipment Maintained Safe, Operating {C 174} SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE **EQUIPMENT** (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. (i) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 3. The outlet at the front porch does not have a protective cover. Contract a licensed electrician to install a cover. 05/05/2015-PD: Based on observations during the Follow-Up Survey, the protective cover is still missing. Contact a qualified technician to install a weather-proof cover on the outlet. Proof of completed work must be provided by way of receipts, invoices, photographs, etc. Forward proof of completed work with you plan of correction. 10. The exterior outlet at the back of the facility did not have power and would not reset. Contract a qualified technician to repair or replace this outlet. Provide documentation of the repairs. 05/05/2015-PD: Based on observations during

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
JULIA DI CONNECTION IDENTI ICATION NOWDER.		A. BUILDING: 01		COMPLETED		
		FCL001114	B. WING		05/0	₹ 5/2015
NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY, S	STATE, ZIP CODE			
MERCIFU	JL HANDS		ADO STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 174}	Continued From pa	ge 1	{C 174}			
	power. Contract a or replace this outlet the repairs. Proof of provided by way of	orward proof of completed				
{C 138}	Outside Entrances/	Exits-Single Hand Motion	{C 138}			
	(d) All exit doors lo	NTRANCES AND EXITS ocks must be easily operable, otion, from the inside at all				
	Contract a qualified hardware with single documentation of the 05/05/2015-PD: Bathe Follow-Up Survaction hardware.	ardware is not single action. vendor to replace the e action hardware. Provide he repairs. ased on observations during ey, the door is still not single contract a qualified vendor to re with single action hardware.				

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Division of Health Service Regulation STATE FORM

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number FCL001114	(Y2) Multiple Construction A. Building B. Wing 01 - MAI	N	(Y3) Date of Revisit 5/5/2015
Name of Facility		Street Address, City, State, Zip Code	

1313 ELRADO STREET MERCIFUL HANDS **BURLINGTON, NC 27217**

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix Reg. # LSC	C0143	Correction Completed 05/05/2015	ID Prefix Reg. # LSC	C0155	Correction Completed 05/05/2015	ID Prefix Reg. # LSC	C0157		Correction Completed 05/05/2015
Reg.#			Reg. #			ID Prefix Reg. #			Correction Completed
Reg.#			Reg. #						
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Reg.#			Reg. #			D #			
Reviewed B		I By	Date:	Signature of Sur	rveyor:			Date:	
Reviewed B		I By	Date:	Signature of Sur	rveyor:			Date:	
	o Survey Completed or 11/13/2014			Check for any Unco Uncorrected Defic				YES	NO
STATE FOR	M: REVISIT REPORT (5	5/99)		Page 1 of 1			Event ID: 9	40522	

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number FCL001114	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN	(Y3) Date of Revisit 5/5/2015
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Name of Facility

MERCIFUL HANDS

Street Address, City, State, Zip Code 1313 ELRADO STREET

BURLINGTON, NC 27217

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
ID Due fire on	Correction Completed	ID Doofin	Correction Complete	d		Correction Completed
ID Prefix C0	05/05/2015		·			<u> </u>
Reg.# LSC		Reg.# LSC		Reg. # LSC	; 	_
	Correction		Correction			Correction
ID Prefix	Completed	ID Prefix	Complete		·	Completed
Reg.#		Reg. #				_
	Correction		Correction			Correction
	Completed		Complete	d		Completed
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Reg. # LSC		Reg. # LSC		Reg. # LSC	;	
	Correction		Correction			Correction
ID Prefix	Completed	ID Prefix	Complete	d ID Prefix	.	Completed
Reg. #						
LSC		LSC		LSC	<u> </u>	_
	Correction Completed		Correction Complete			Correction Completed
ID Prefix		ID Prefix			·	
Reg. #		Reg.# LSC		Reg. # LSC	<u> </u>	— —
Reviewed By	Reviewed By	Date: Signature of Surveyor:		Date:		
State Agency						
Reviewed By CMS RO		Date:	Signature of Surveyor:		Date:	
Followup to Su	irvey Completed on:		Check for any Uncorrected De Uncorrected Deficiencies (NO
STATE FORM: R	REVISIT REPORT (5/99)	I	Page 1 of 1		Event ID: 940522	